Informational Hearing

Transparent Reporting of Quality Data and Outcomes

Tuesday, February 17, 2009
1:30 p.m. – 3:30 p.m.
State Capitol
Room 4202

What is transparency in health care?

The National Quality Forum (NQF), in a background paper on health care cost and price transparency, defines cost and price transparency as the provision of useable financial information to a specific audience. The concept behind price transparency in health care is to make comparative information on the price and/or quality of health care providers for specific services publicly available. Similarly, quality transparency is the provision of useable information on quality of care.

The goals of transparency include:

- Encourage consumers, purchasers, and employers to consider price and quality when deciding among health care providers and services;
- Improve health care outcomes for patients by providing information they can use to select health plans and health care providers based on quality and cost;
- Provide feedback to health care providers and health plans so they can benchmark their own performance in meeting quality standards;
- Help providers identify areas for improvement in quality;
- Slow the rate of growth of health care expenditures by fostering price competition and controlling health care costs;
- Encourage third-party payers to reward quality and efficiency;
- Establish greater public accountability for the quality and affordability of care; and,
- Foster a more value-driven health care delivery system.

Why is transparency in health care important?

According to studies funded by the Commonwealth Fund, the U.S. health system is the most expensive in the world, but consistently underperforms relative to other countries on most dimensions of performance. In 2008, one such study ranked the U.S. last among the 19 industrialized nations, with the highest proportion of deaths that could have been prevented by proper health care. The authors estimated that more than 75,000 deaths could have been averted in one year.[i] In a 2004 health policy assessment on health care in California, RAND stated that American adults were receiving about one-half of recommended medical services—that is, services shown in the scientific literature to be effective in specific circumstances and agreed upon by medical experts.[ii] The RAND policy assessment stated deficits in quality of care across all types of care—chronic, preventive, and acute. Recommended care for managing chronic conditions (e.g., diabetes and hypertension) was provided 56% of the time, preventive care (e.g., flu shots, mammograms and smoking cessation counseling) met quality standards 55% of the time and recommended care for acute health problems (e.g., pneumonia and urinary tract infections) was provided 54% of the time. RAND also found wide variation in the proportion of recommended care provided for some specific conditions. For example, recommended care for heart and lung problems ranged from 25% for atrial fibrillation (irregular heart rate) to 68% for coronary artery disease. Additionally, the Institute of Medicine (IOM) estimated that medical errors kill between 44,000 and 98,000 people annually, exceeding breast cancer, AIDS, or motor vehicle accidents as causes of death.[iii] Meanwhile, U.S. health care costs are rising much faster than wages and productivity, and insured consumers are paying for a greater share of their health care as deductibles and copayments rise.

The problem of uneven quality and soaring costs has led to a call for transparency in quality and costs of care. Better public information on cost and quality is important because it should help providers improve by allowing them to compare their performance with others, encourage payers to reward quality and efficiency, and help patients make informed choices about their care.

How has the Legislature addressed transparency in health care?

In the previous legislative session, the Legislature heard several bills relating to transparency in health care. ABX1 1 (Nunez) and AB 8 (Nunez) would have established a committee or commission to develop a plan to improve and expand public reporting of health care safety, quality, and cost information. ABX1 1 would have also required the Office of Statewide Health Planning and Development (OSHPD) to publish risk-adjusted outcome reports for percutaneous coronary interventions (for example, angioplasty and stents), and to compare risk-adjusted outcomes by hospital and physician. AB 8 would have additionally required its commission to publicly report certain patient safety and quality indicators, and health care associated infection rates. AB 8 was vetoed by Governor Schwarzenegger and ABX1 1 failed passage in the Senate Health Committee.

Last year's AB 2967 (Lieber) was similar to the transparency provisions of ABX1 1, but was placed on the inactive file in the Senate after amendments adopted in the Senate Appropriations Committee as the bill moved off the suspense file were unacceptable to the bill's author and proponents. Additionally, SB 1300 (Corbett) of 2008 would have prohibited a contract between a health care provider and a health plan from containing a provision that restricts the ability of the health plan to furnish information on the cost of procedures or health care quality information to health plan enrollees. The Senate refused to concur with Assembly amendments to SB 1300.

How is quality defined and measured?

Dimensions of Quality in Health Care

Various efforts address the question of quality in health care. The IOM identified six aims for quality in health care. Specifically, IOM states that health care should be: 1) safe; 2) timely; 3) effective; 4) patient-centered; 5) efficient; and, 6) equitable.[vi]

Hospital care

Under the auspices of the federal Agency for Healthcare Research and Quality (AHRQ) investigators at Stanford University and the University of California developed Quality Indicators, including the Inpatient Quality Indicators (IQIs), which are used to measure hospital quality of care. The IQIs are a software tool distributed at no charge by AHRQ that use readily available hospital administrative data to help hospitals identify potential problems that warrant further study and which can provide an indirect measure of the quality of hospital care. IQIs include inpatient mortality for certain procedures and medical conditions; utilization of procedures for which there are questions of overuse, underuse, and misuse; and volume of procedures for which there is some evidence that a higher volume of procedures is associated with lower mortality.[vii] When provided to the public, IQIs enable consumers and payers to compare hospitals based on various indicators of quality.

Health Plans

The National Committee for Quality Assurance (NCQA) developed the Healthcare Effectiveness Data and Information Set (HEDIS) as a tool to measure performance and provide purchasers and consumers with the information they need to reliably compare the performance of health plans. HEDIS consists of 71 measures across eight domains of care. Examples of HEDIS measures include: asthma medication use; persistence of beta-blocker treatment after a heart attack; control of high blood pressure; comprehensive diabetes care; breast cancer screening; antidepressant management; immunization status; and, smoking cessation advice.

The NCQA reports that more than 90% of America's health plans use HEDIS. Because so many plans collect HEDIS data, and because the measures are specific, HEDIS enables comparison of health plan performance on an "apples-to-apples" basis. HEDIS

data are also the main data source for most health plan report cards that appear in national magazines and local newspapers. Health plans also use HEDIS results to identify areas for improvement. In 2008, the NCQA required all health plans to report HEDIS measures as a condition of accreditation. The NCQA states that reporting by health plans drives improvement in the quality of care, noting that for nine consecutive years health plans that reported HEDIS measures improved overall quality of care.

Transparency Efforts in California

OSHPD

OSHPD was created in 1978 within the California Health and Human Services Agency (CHHSA) to provide the State with an enhanced understanding of the structure and function of its healthcare delivery systems. OSHPD now collects data and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes, among many other functions.

In 1985, the Legislature established the California Health Policy and Data Advisory Commission (CHPDAC) to advise OSHPD and the CHHSA on health policy and health information issues, including the collection and dissemination of useful and appropriate data on health care quality and costs. CHPDAC is made up of 13 commissioners, each representing a major stakeholder in the health care delivery system. The Governor appoints nine members as follows: 1) one hospital chief executive officer (CEO); 2) one CEO of a hospital serving a disproportionate share of low-income patients; 3) one CEO of a long-term care facility; 4) one CEO of a freestanding ambulatory surgery clinic; 5) one health insurance industry representative involved in establishing premiums or underwriting; 6) one representative of a group prepayment health care service plan; 7) one representative of a business coalition concerned with health; and, 8) two general members. The Speaker of the Assembly appoints one physician and one general member. The Senate Rules Committee appoints one representative of a labor coalition concerned with health and one general member. There is concern that the composition of CHPDAC is heavily weighted toward health care providers, at the expense of the interests of consumers and purchasers of health care, who stand to benefit from transparency. Because of this, several of the transparency proposals the Legislature considered in the previous legislative session would have created an advisory committee which had greater representation of health care consumers and purchasers.

CHPDAC currently has three committees. The AB 524 Technical Advisory Committee provides advice on risk-adjusted outcome studies of California hospitals. The Appeals Committee hears appeals by facilities that are fined for late reporting of data to OSHPD. The Health Data and Public Information Committee reviews data needs and health planning issues relating to a variety of health facilities, and promotes public access to health care data.

OSHPD collects financial data and data on health facilities and clinics, including services provided, number of visits, and patient demographic information. OSHPD also collects from licensed hospitals patient-level discharge data, which includes demographics, diagnoses, medical procedures, medical disposition, total charges, and expected source of payment. Notably, the information that OSHPD provides to the public for the purposes of comparing hospital prices are limited to charges; actual payments often vary from charges depending on contracts with payers and other factors.

OSHPD's work to enhance quality transparency includes numerous reports, including reports comparing hospitals on outcomes for patients with community-acquired pneumonia; outcomes of coronary artery bypass graft surgery (CABG); and outcomes of acute myocardial infarction (heart attack). OSHPD also compares surgeon performance based on CABG outcomes. In addition, OSHPD has reported on racial and ethnic disparities in health care by examining preventable hospital admissions, mortality in hospitals, and the use of invasive cardiovascular procedures. OSHPD had developed its own methodology to compare hospital performance, but now uses AHRQ's IQIs to compare hospital performance. OSHPD has recently published reports that compare individual hospital outcomes for five procedure-based IQIs, and three IQIs based on medical conditions. Beginning in July 1993, OSHPD was legislatively mandated to begin publishing annual hospital quality reports. Beginning in July 1995, OSHPD must publish these reports on at least nine procedures and conditions. OSHPD has recently issued reports using IQIs and separate reports on CABG outcomes and community-acquired pneumonia outcomes, thereby satisfying its statutory mandates. OSHPD did not complete all of its statutorily mandated reports in the past; however, OSHPD has stated that with the use of IQIs, it will be able to produce more timely reports.

The California Department of Public Health (CDPH)

SB 1301 (Alquist), Chapter 647, Statutes of 2006, was intended to improve hospital quality by improving timelines for hospital inspections and establishing consumer-oriented information on compliance performance. SB 1301 requires general acute care hospitals, acute psychiatric hospitals, and special hospitals to report adverse events to CDPH within specified time frames, and CDPH to make onsite inspections or investigations within two business days of receipt of a report that indicates an ongoing threat of imminent danger. An "adverse event" is defined as an event or series of events that causes the death or serious disability of a patient, personnel, or visitor, and includes any of 27 specified occurrences, including the following:

- Surgical events, such as surgery performed on a wrong body part;
- Product or device events, such as patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants;
- Patient protection events, such as an infant discharged to the wrong person;
- Care management events, such as a patient death or serious disability associated with a medication error;

- Environmental events, such as a patient death or serious disability associated with an unplanned electric shock; and,
- Criminal events, such as any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

SB 1301 also requires CDPH, by January 1, 2009, to provide information regarding reports of adverse events and the outcomes of inspections on the CDPH website and in a written form accessible to consumers.
As of this writing, the SB 1301 report was not available at the CDPH web site. In July 2007, CDPH issued an all facilities letter which explained the new statute, including a list of reportable events and penalties for failure to report adverse events.

Office of the Patient Advocate

The Office of the Patient Advocate (OPA) within the Department of Managed Health Care (DMHC) is charged with representing the interests of enrollees of health plans (generally health maintenance organizations [HMOs]) regulated by the DMHC. Established by legislation creating the DMHC (AB 78, [Gallegos], Chapter 525, Statutes of 1999), the OPA is headed by a patient advocate recommended to the Governor by the Secretary of the Business, Transportation and Housing Agency.

The duties of the OPA include, but are not limited to, the following:

- Developing educational and informational guides for consumers that describe health plan enrollee rights and responsibilities, and inform enrollees of effective ways to exercise their rights to secure health care services. The guides must be easy to read and understand, available in English and other languages, and be made available to the public by DMHC, including through DMHC's web site and through public outreach and educational programs; and,

- Compiling an annual quality of care report card. The report card produced by OPA provides information on the quality of care provided by health plans and medical groups that is based on whether they meet national standards of care in the following areas:

    - Asthma care;
    - Cancer screening;
    - Chlamydia screening;
    - Diabetes care;
    - Heart care;
    - Maternity care;

- Mental health care;
- Treating for cause of back pain;
- Treating adults; getting the right care;
- Treating bronchitis with antibiotics; and,
- Treating children (immunizations, treatment for throat infections).

The OPA report card also provides information on plan language services, and how plan and medical group enrollees rate their particular plan/group in the following areas:

- Doctor communications (communication with patients, shared decision making, coordinated care, treatment options are explained, prevention discussed);
- Access to doctors and care (getting appointments and care quickly);
- HMO customer service (answering telephone calls quickly, ease of finding a personal doctor); and,
- Member complaints (satisfaction with how complaints were handled by the plan).

Additionally, the OPA web site provides links to other web sites, such as the California Healthcare Foundation's (CHCF) web site with information on hospital and nursing homes and the federal government's web site with Medicare information.

California Hospital Assessment and Reporting Taskforce (CHART)

Researchers at the University of California, San Francisco (UCSF) and CHCF established CHART in 2004 to address the need for health care cost and quality transparency by investigating the feasibility of producing a statewide hospital report card through a collaborative process involving a broad group of stakeholders. Participants included representatives from hospitals, health plans, health care purchasers and the business community, consumers, researchers, and government.

In the investigative phase of the CHART project (from May 2004 to July 2005), the team adopted more than 50 hospital performance indicators that were to be collected in 2005 and 2006. The performance measures include process and outcome measures in specific clinical areas such as cardiac care, maternity, pneumonia treatment, and intensive care, as well as hospital-wide outcomes in areas such as patient experience, nursing-sensitive measures, and appropriateness of cardiac procedures. The team agreed on processes for data collection, aggregation, and auditing, and evaluated means to translate complex data into consumer-friendly decision-support tools.

More than 200 hospitals representing 70% of all hospital admissions in California agreed to participate in CHART. In addition, California's major health plans have agreed to use the data as the basis for quality reporting and have committed to providing some financial support. In addition to CHCF, other organizations now provide financial support to the CHART project. CHART released its first public report card in March 2007 at

CalHospitalCompare.org. The research group at UCSF continues to coordinate with the CHART steering committee and other advisory groups and workgroups.

Challenges Ahead

Making information available is not enough to help consumers use the information effectively. The National Quality Forum (NQF) found that the available cost information was often either too detailed or too general to be useful to consumers. Useful information enables comparisons among providers and different treatment options; is easy to read; covers all the costs associated with a given episode of care ("bundled"); and is linked to information on quality. The NQF concluded that information should address the actual financial liability consumers face, such as copays, deductibles, and exclusions. Those without health coverage typically need information on payment plans, how to negotiate charges, and how to get financial assistance.[ix]

The NQF highlighted two other concerns over price transparency. First, providers may be concerned about violating federal antitrust laws if they publicize negotiated prices. However, in 1996 the federal government established an antitrust "safety zone," one condition of which is that pricing shown by third parties be at least three months old. Second, economists have found that cost transparency can lead to higher prices in markets where there is little competition. The NQF notes that if cost information is bundled, however, it is less likely to lead to cost inflation.

A recent report from the Center for Studying Health System Change notes that health plan quality and price transparency efforts are largely in the early stages and had a limited impact. Progress in reporting quality to enrollees has not quite kept pace with measuring quality, and price transparency is generally even further behind.[x] In order for transparency to improve health care quality and achieve cost control, we will need to better understand what information consumers and payers want and can use, and how best to provide this information.

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[i] S. R. Collins and K. Davis, Transparency in Health Care: The Time Has Come, The Commonwealth Fund, March 15, 2006

[ii] Rand Health and The Communication Institute, "Health Care in California – A Policy Assessment,"2004.

[iii] Institute of Medicine, "To Err is Human," November 1999.

[vi] Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century," March 2001.

[vii] http://www.qualityindicators.ahrq.gov/iqi_overview.htm (accessed 2/11/09)

[ix] California Healthcare Foundation, "Making Health Care Costs More Transparent to Consumers: A Summary for Policymakers," February 2008.

[x] Tynan A., Liebhaber A, Ginsburg P. "A Health Plan Work in Progress: Hospital-Physician Price and Quality Transparency," Center for Studying Health System Change, August 2008.